dures used in the UA patients during hospital stay are reported below:

Hospital	Type I (n.30)	Type II (n.859)	TypeIII (n.357)	Type IV (n.374)	Total (n.1420)
Noninvasive procedures (NIP) %					
Holter	30	33	22	13	25
Exercise stress test	27	26	23	20	24
Echocardiogram	83	77	50	53	64
Echo-stress	3	5	2	3	4
Nuclear cardiology	–	2	3	3	3
Invasive procedures (IP) %					
Coronary angiography	3	13	58	68	39
PTCA	–	1	7	34	11
CABS	–	0.5	1	7	2

Type I: no CCU, no Cath Lab, no cardiac surgery (CS); Type II: CCU, no Cath Lab, no CS; Type III: CCU, Cath Lab, no CS; Type IV: CCU, CathLab, CS.

CONCLUSION: In Italy the number of hospital admissions due to UA is similar to that due to AMI. NIP were performed more frequently in the hospitals without CathLab/CS. Hospitals' more than patients' characteristics induced IP.

PCV12

ONE-YEAR CLINICAL AND ECONOMIC OUTCOMES OF PRIMARY CORONARY ANGIOPLASTY USING A NATIONAL DATABASE

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OBJECTIVE: To determine clinical and economic outcomes of primary PTCA and assess the effects of comorbidities (congestive heart failure, diabetes, hypercholesterolemia, hypertension) on outcomes using a national database.

METHODS: Data were obtained from MarketScanâ Medstatâ, which contains claims data for 4–5 million people. Patients with a hospital admission for PTCA (CPT codes 92982, 92984) in 1992 and one year of follow-up charge data were identified. A total of 2,663 patients with a single vessel and 331 with a multiple vessel procedure were included. Patients who died or were missing prior to one-year follow-up were excluded (n = 653). Total charges were calculated by summing charges for the index procedure plus all inpatient and outpatient charges incurred during the year following PTCA. Multivariate regression was used to assess effects of comorbidities on outcomes (adjusted for age and other factors).

RESULTS: Patients with single vessel versus multiple vessel PTCA did not differ according to comorbid and other characteristics, or most clinical or economic outcomes; therefore combined data are presented. The frequency of clinical outcomes in the year following PTCA was: rehospitalization for angina–41%, myocardial infarction (MI)–33%, repeat PTCA–15%, coronary artery bypass grafting–7%, and stroke–3%. Comorbidities related to clinical outcomes were: congestive heart failure (CHF) for MI ($p = 0.0001$), diabetes for angina rehospitalization ($p = 0.06$), and diabetes ($p = 0.05$) and hypertension ($p = 0.004$) for repeat PTCA. Total charges per patient at one year after primary PTCA were $35,257, and total charges were strongly related to the presence of diabetes ($p = 0.001$) and CHF ($p = 0.001$). There was no association with hypertension or hypercholesterolemia.

CONCLUSION: These findings show that the presence of certain comorbid factors does influence clinical and economic outcomes following PTCA.

PCV13

PREVALENCE AND COST OF HOSPITALIZATIONS DUE TO ANGINA IN THE UNITED STATES USING A NATIONAL DATABASE

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This study describes the prevalence and cost of hospitalizations due to angina in the United States.

METHODS: Using the 1992 Health Care Utilization (HCUP) database, patients admitted with the principle diagnosis of angina (ICD-9 codes 411.1, 413.1, 413.9) were identified. Results were analyzed based on demographic distribution, procedures performed, mean length of stay (LOS), and total charges.

RESULTS: The overall prevalence of hospitalizations due to angina was 2.6%. The highest angina hospitalization rates were among patients between the ages of 55–75 years (5.6%), male (3.4%), and white (3.1%). The most common type of diagnosis was unstable angina (79%), followed by stable angina (19.8%). More than half (55%) of admissions were through the emergency room (ER), and 7.3 % were routine admissions. The most common procedures were removal of coronary artery obstruction (ICD-9 code 36), followed by other operations on heart and pericardium (ICD-9 code 37). The mean LOS and total charges were 4.87 days and $12,134, respectively. Mean LOS and total charges per admission varied significantly according to admission source: 4.6, 5.0, 6.9 days and $9,130, $15,120, $24,090 for ER admission, routine admission, and others (e.g., hospital transfer), respectively. Since HCUP represents a 20% sample of total US hospitalizations, total annual charges for hospitalizations due to angina are approximately $10 billion, and the majority of that ($8.7 billion) is due to unstable angina.

CONCLUSION: Hospitalization due to unstable angina is the major cost component of the total cost of hospital care for angina in the United States.